STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 120317-001**

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 28th day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 29, 2011, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.*

BCBSM pointed out in its response to the request that the services at issue in this case were rendered in 2006, more than four years ago. It states that under the terms of the Petitioner's contract, legal action must be initiated against BCBSM not later than two years after BCBSM has received a completed claim for the services. However, there is nothing in the record that explains when BCBSM received a completed claim. Moreover, BCBSM afforded the Petitioner the right to an internal grievance in February 2011 and then informed her in its final adverse determination at the conclusion of that process that she had the right to request an external review by the Commissioner under PRIRA.

The Commissioner finds that the Petitioner has satisfied the requirements of PRIRA in her request for an external review. Under PRIRA, she had 60 days from the date she received a final adverse determination to request an external review. The final adverse determination was dated February 10, 2011, and the Petitioner's request for an external review was received on March 29, 2011, within the 60 day period. After a preliminary review of the request, the

Commissioner accepted it on April 5, 2011.

Because it involved medical issues, the case was assigned to an independent review organization which provided its analysis and recommendations on April 19, 2011.

II. FACTUAL BACKGROUND

The Petitioner receives health care benefits as an eligible dependent under her husband's nongroup coverage. Her benefits are defined in the Blue Cross Blue Shield of Michigan (BCBSM) *Nongroup Comprehensive Health Care Benefit Certificate* (the certificate).

From October 19 to November 10, 2006, the Petitioner received inpatient services at XXXXX in XXXXX, while participating in a XXXXX pain rehabilitation program related to her migraine headaches. The total amount charged by XXXXX for this care was $16,327. BCBSM's paid its approved amount for part of the care but denied coverage for health and behavior intervention services as not medically necessary. A total of $11,956 in charges remains in dispute.

The Petitioner appealed the denial of coverage through BCBSM's internal grievance process. Following a managerial-level conference on February 10, 2011, BCBSM did not change its decision and issued a final adverse determination dated that same day.

III. ISSUE

Did BCBSM properly deny coverage for the Petitioner's health and behavior intervention services at XXXXX Hospital from October 19 to November 10, 2006?

IV. ANALYSIS

BCBSM's Argument

BCBSM states that services must be medically necessary to be covered. The certificate (pp. 6.13 – 6.14) explains medical necessity:

> A service must be medically necessary to be covered. There are two definitions; one applies to physician services and one applies to hospital services.
>
> * * *
>
> • Medical necessity for payment of hospital . . . services:
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> Determination by BCBSM that allows for the payment of covered hospital services when all of the following conditions are met:
>
> - The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.

- The service, treatment, or supply is **appropriate** for the symptoms and is consistent with the diagnosis.

  Appropriate means that the type, level and length of care, treatment or supply and setting is needed to provide safe and adequate care and treatment.

BCBSM argues a portion of the hospital services the Petitioner received were not medically necessary as defined in the certificate. According to BCBSM, her services at XXXXX were billed as health and behavior intervention (CPT code 96153). BCBSM's medical policy title "Health and Behavioral Assessment/Intervention," explains when health and behavioral intervention is considered reasonable and medically necessary:

> Health and Behavior Intervention procedures are used to modify the psychological, behavioral, emotional, cognitive and social factors identified as important to or directly affecting the patient's physiological functioning, health and well being or response to specific disease-related problems.
>
> These procedures represent services that can be offered to patients who:
>
> - Have established illnesses or symptoms.
> - Who are *not* diagnosed with a mental illness according to the Diagnostic and Statistical Manual of the American Psychiatric Association Fourth Edition-DSM-IV and the International Classification of Diseases Ninth Edition with Clinical Modification-ICD-9-CM, and
> - Who may benefit from evaluations and treatments that focus on the biopsychosocial factors related to the patient's physical health status such as:
>   - Patient adherence to medical treatment.
>   - Symptom management and expression.
>   - Health-promoting behaviors.
>   - Health-related risk-taking behaviors.
>   - Overall adjustment to physical illness.

Health and behavior intervention modifies the psychological, behavioral, emotional, cognitive, and social factors important to the prevention or management of physical health problems. Thus, the intervention is only covered if the patient does not have a mental illness. BCBSM notes that Petitioner's medical documentation indicates she was diagnosed with bipolar disorder and depression, for which she took medication. BCBSM indicates these disorders are mental illnesses and therefore she does not meet the criteria for payment of health and behavior intervention. BCBSM submits that its denial of coverage for the care at XXXXX was correct.

Petitioner's Argument

The Petitioner has a history of migraines with associated depressive symptoms and anxiety. Before receiving services at XXXXX Hospital, she was evaluated for chronic head pain, which was diagnosed as a transformed migraine, as well as chronic neck pain with degenerative arthritis of the spine.

The Petitioner states the treatment prescribed by the XXXXX Center was for the treatment of migraine headaches not bipolar disorder, depression, or mental illness. She further states that the services were for the treatment or diagnosis of an injury, condition, or disease and the care was appropriate for her symptoms and diagnosis. The Petitioner argues that all of her problems resolved after her treatment at XXXXX and it has been over four years since she has had a migraine headache.

The Petitioner believes that all of the care she received at XXXXX Hospital was medically necessary and should be covered under the terms of the certificate.

Commissioner's Review

The question of whether the Petitioner's care at XXXXX Hospital was medically necessary was presented to an independent review organization (IRO) for analysis, as required by Section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6).

The IRO reviewer is a physician who is certified by the American Board of Psychiatry and Neurology with a sub-specialty in psychiatry and adult psychopharmacology; is an assistant clinical professor of psychiatry at a university-based school of medicine; is a member of the American Psychiatric Association; and is in active clinical practice. The IRO report contained the following analysis and recommendation:

> It is the determination of this reviewer that medical necessity has not been established for the health and behavioral intervention services for dates of service October 19, 2006 through November 11, 2006.
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> The health and behavioral intervention service for dates of service October 19, 2006 - November 11, 2006, were considered Psychiatric in nature.
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> **Clinical Rationale for the Decision:**
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> Based upon the available clinical information, the treatment was primarily psychiatric, although medical issues were also addressed by various specialists during her stay. The presenting complaints were severe pain, depression, and isolation from family and friends. The enrollee's primary diagnosis was somatization disorder with headaches. (Prior to admission, the enrollee was taking

> medications for bipolar disorder and anxiety, and was seeing a psychotherapist.)
>
> The Pain Rehabilitation notes emphasize the enrollee's mental status. A significant component of the enrollee's treatment was the tapering of several psychotropic medications, with emphasis on Ativan, which she had been taking for 17 years at a relatively high dose of 4-5mg daily. . . .
>
> * * *
>
> This patient encounter did not meet the [American Psychiatric Association and Milliman Care Guidelines] and, therefore, the treatment of the patient's psychiatric and associated pain problems did not require an inpatient setting. At the time of admission, she was on psychotropic medications but was not being treated by a psychiatrist. She had been in psychotherapy for many years. She was depressed upon admission to the PRC program and reported social isolation, but there was no evidence of suicidal ideation, psychosis, imminent danger to self or to others, or inability to care for her basic needs. Only mild, intermittent cognitive deficits were noted. The enrollee's psychiatric issues could safely and effectively have been addressed by a comprehensive outpatient psychiatric evaluation, with subsequent treatment to follow from the outcome of such an evaluation. Tapering of the enrollee's Ativan could readily have been accomplished on an outpatient basis, and the issues surrounding her psychotropic medications addressed likewise.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO's recommendation is afforded deference by the Commissioner. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b). The IRO reviewer's analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in the present case.

The Commissioner finds that BCBSM's denial of coverage for a portion of the Petitioner's care at XXXXX Hospital as not medically necessary for treatment of her condition is consistent with the terms of the certificate.

V. ORDER

Respondent BCBSM's February 10, 2011, final adverse determination is upheld. BCBSM is not required to cover the Petitioner's health and behavior intervention services at XXXXX Hospital from October 19 to November 10, 2006.

Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner